(38)

No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF THE MEDICAL SOCIETY OF NEW JERSEY AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

VINCENT A. MARESSA
NEIL E. WEISFELD
THE MEDICAL SOCIETY
OF NEW JERSEY
Two Princess Road
Lawrenceville, New Jersey 08648-2302
(609) 896-1766

PAUL W. ARMSTRONG*
R. BRUCE CRELIN
TIMINS, LARSEN, BEACHAM
& HUGHES
85 Livingston Avenue
Roseland, New Jersey 07068
(201) 740-1771

* Counsel of Record

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INTEREST OF THE AMICUS CURIAE

Amicus Curiae, the Medical Society of New Jersey (MSNJ), respectfully submits this brief in support of the Petitioners. The MSNJ has obtained the written consent of both the Peti-

tioners and the Respondents to the filing of this brief *amicus curiae*.[1]

Founded in 1766, the MSNJ (our nation's first state society of physicians) is the primary organization of physicians in New Jersey. Approximately nine thousand five hundred physicians hold individual memberships in the MSNJ. For more than 230 years, the Medical Society of New Jersey has been the state's leading voice in the health care field. The MSNJ's mission is to promote the quality of health care and health services for all citizens of the state and to supply leadership and assistance to its physician members. To fulfill this mission the MSNJ regularly participates in important issues in the judicial, legislative and regulatory arenas.

The MSNJ has played a leadership role concerning contemporary legal and ethical issues confronting modern medical practice and has historically helped to shape and implement landmark judicial and legislative initiatives concerning life sustaining technologies and end of life decisionmaking. Through its Committee on Biomedical Ethics, the MSNJ has developed policies and positions addressing the roles of physicians, patients and hospitals and their concomitant rights, duties and obligations to the larger society physicians are privileged to serve.

As a leader in the health care field, as the representative of those physicians who bear the primary and sacred responsibility for the integrity of the medical profession, and as a contributor to the legal, medical and ethical debate, the MSNJ is vitally concerned about the lack of precedent, measure, balance and wisdom in the decision of the Second Circuit, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), legitimizing assistance in patient self-destruction. This ruling is clearly violative of the duties, prerogatives and responsibilities of the healing professions.

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[1] The letters providing consent from all parties have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

The physician members of the Medical Society of New Jersey, as pioneers in developing and guardians in the exercise of patients' rights,[2] submit that the past pronouncements of this Court justify state initiatives, which are informed and authenticated by the ethos of medicine, prohibiting assistance in patient self-destruction.

ARGUMENT

Informed, compassionate decision making routinely occurs within the physician-patient relationship. Since time out of memory, the ethical traditions of medicine have affirmed life as sacred and prohibited its taking. This Court should reject the Second Circuit's invitation to contemn the ancient canons of the healing arts.

I. THE ETHOS OF MEDICINE DOES NOT COUNTENANCE ASSISTANCE IN SELF-DESTRUCTION

A. History and Tradition Forbid Physician Assistance in Patient Suicide

The prohibition of physician assistance in patient self-destruction is as deeply rooted as any tradition defining the ethical practice of medicine. Ancient and contemporary medical canons have, for millennia, affirmed the sacredness of human life and enjoined purposeful medical assistance in killing the patient.

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[2] The MSNJ's position should not be interpreted in any way so as to compromise the ethically and legally protected right of terminally ill patients to participate fully in treatment decisions at the end of life, including the right to execute and implement advance directives and to refuse or request the withdrawal of aggressive forms of medical treatment which in the informed opinion of the patient impose burdens which outweigh the benefits. *See* Medical Society of New Jersey, *Statement on Physician Assisted Suicide*, App. A.

In 410 B.C., Hippocrates charged practitioners of the medical arts to ". . . give no deadly medicine to anyone if asked, nor suggest any such counsel."[3] Two thousand, four hundred and four years later, the American Medical Association affirmed this signal conviction in § 2.211 of its Code of Medical Ethics:

> **Physician Assisted Suicide.** Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress-such as those suffering from a terminal, painful, debilitating illness-may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.[4]

Mindful of its central role in helping to shape and implement several landmark judicial opinions and legislative

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[3] Hippocrates, The Oath (W.H.S. Jones trans., Loeb Classical Library 1923).

[4] See AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* ("*Code of Medical Ethics*") § 2.211, App. E.

initiatives concerning life sustaining technologies and end of life decisions,[5] the Medical Society of New Jersey has iterated the core of the profession's long standing opposition to the unlawful taking of human life: "Moreover, under physician assisted suicide, the medical profession's devotion to healing and refusal to kill, its ethical center, would be destroyed along with patient trust and physician self-constraint. Physicians do not require the tool of death."[6]

Throughout history it has been the physician's duty and responsibility to attend to the sick and dying. The members of the MSNJ hold that this sacred trust is best discharged by unwavering fidelity to ancient mileposts which respect that human life is sacred and that the healing arts adhere to the inviolable rule that doctors must not kill.[7]

The Medical Society of New Jersey submits that under these policies, the patient's role as the focal point of medical decision making is safeguarded and the integrity of the physician-patient relationship preserved by precluding the undermining acts which intentionally cause the death of the patient. The members of the Medical Society of New Jersey routinely rely upon these fundamental maxims when providing care to all patients.

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[5] *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *Matter of Peter by Johanning*, 108 N.J. 365, 529 A.2d 319 (1987); *Matter of Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); N.J.S. 26:2H-53 to 78 and N.J.S. 52:27G-5.1 to 25.1.

[6] See Medical Society of New Jersey, *Statement on Physician Assisted Suicide*, 1 November 1996, App. A.

[7] Of an important ethical piece is the 12 September 1982 Medical Society of New Jersey *Policy Statement on Physician Administered Injections As a Means of Execution*, which holds that ". . . participation would undermine the moral and ethical foundations of medicine." App. B.

B. Decisions To Forego Life-Sustaining Treatment Are Profoundly Separate from Elections To Assist in Patient Self-Destruction

An individual's constitutional right to refuse life-prolonging medical treatment was first embraced by the New Jersey Supreme Court in its seminal decision concerning the plight of Karen Ann Quinlan, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), and numerous state courts have affirmed the prerogatives reflected in the Medical Society of New Jersey's commitment to respect for patient decisions.[8]

Citing this Court and specific articles of the New Jersey constitution, the unanimous *Quinlan* court held: "We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support . . . in the face of irreversible, painful and certain imminent death." *Quinlan*, 70 N.J. at 43.[9]

Scholarly support for this crucial distinction is legion and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research underscored the critical variance: ". . . although declining to start or continue life-sustaining treatment is often acceptable, health care providers properly refuse to honor a patient's request to be directly killed. Not only would killing, as by violence or strychnine, be outside the bounds of accepted medical practice, but as murder it would be subject to a range

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[8] *See* National Center for State Courts, *Guidelines for State Court Decision Making in Authorizing or Withholding Life-Sustaining Medical Treatment* (1991), and Appendix A, the MSNJ's *Statement on Physician Assisted Suicide*.

[9] Since the *Quinlan* decision, state courts have uniformly embraced the significant moral and legal distinctions between letting die and killing (assisted suicide and euthanasia). *See also In re Conroy*, 98 N.J. at 350-351, National Center for State Courts, *Guidelines*, cited in f.n. 7, *supra*.

of criminal sanctions, regardless of the provider's motives." *Deciding to Forego Life Sustaining Treatment* (1983), at 63-64.

Widespread medical and public concern about drawing a line between a patient's right to choose medical treatment, on one side, and euthanasia or "mercy killing" and physician assistance in self-destruction, on the other led the Hastings Center to promulgate its report *Guidelines on the Termination of Life Sustaining Treatment and the Care of the Dying* (1987). While firmly endorsing the right of a competent patient, or surrogate for an incompetent patient, to forego life-sustaining medical treatments, the *Guidelines* roundly rejected euthanasia and assisted suicide:

> Medical tradition and customary practice distinguish in a broadly acceptable fashion between the refusal of medical interventions and intentionally causing death or assisting suicide. This tradition does not hold the health care professional morally responsible for the death of a patient when life-sustaining treatment is refused and the professional's purpose is not to cause death, but to honor the refusal. Similarly, the tradition defends the administration of a treatment that may hasten death when the professional's purpose is to relieve pain and suffering and the patient or surrogate consents. By contrast, this tradition does not permit administering massive doses of sedatives for the purpose of bringing about death, even if requested by the patient or surrogate.

Guidelines at 128.

The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and its sister commission, The New York State Task Force on Life and the Law, concluded that while competent adults have the fundamental right, in collaboration with their health care providers, to control decisions about their medical care, that prerogative is not absolute and is subject to certain interests of soci-

ety.[10] In its 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, the New York Task Force unanimously recommended that:

> New York laws prohibiting assisted suicide and euthanasia should not be changed. In essence, we propose a clear line for public policies and medical practice between foregoing medical interventions and assistance to commit suicide or euthanasia. Decisions to forego treatment are an integral part of medical practice; the use of many treatments would be inconceivable without the ability to withhold or to stop the treatments in appropriate cases. We have identified the wishes and interests of patients as the primary guideposts for those decisions. Assisted suicide and euthanasia would carry us into new terrain - American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.

When Death Is Sought at vii-viii.

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10 New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, *The New Jersey Advance Directives for Health Care and Declaration of Death Acts: Statutes, Commentaries and Analyses* (Princeton, 1991), App. F.

The policies and pronouncements of the Medical Society of New Jersey and the American Medical Association have helped to shape the broad legal and ethical consensus surrounding the recognition and vindication of patients' rights to forego life sustaining treatments[11] as well as prohibitions against assistance in their self destruction.[12]

Within the physician-patient relationship, physicians have a legal and ethical duty to the patient to ensure that treatment decisions are made which foster and protect the patient's best interests. *See* American Medical Association, *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association*, Opinion 9.12 (1994). This duty extends to assisting our nation's highest tribunal as society wrestles with a critical case of first impression. The physician-patient relationship has historically played a central role in guarding the patient from treatment decisions which are inconsistent with sound medical practice and ethical conduct.

The members of the Medical Society of New Jersey submit that, by curing the failure of the Second Circuit's opinion to constitutionally recognize the critical variance between refusal of life-sustaining treatment and assistance in self-destruction, this Court will restore respect for patient sovereignty deeply rooted in accepted medical, ethical and legal principles.

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11 American Medical Association Opinion 2.20: *Withholding or Withdrawing Life-Sustaining Medical Treatment*, App. C.

12 Medical Society of New Jersey, *Statement on Physician Assisted Suicide*, App. A. American Medical Association Opinion 2.20; *Withholding or Withdrawing Life-Sustaining Medical Treatment*, App. C. American Medical Association Opinion 2.211; *Physician Assisted Suicide*, App. E. American Medical Association Opinion 2.21; *Euthanasia*, App. D.

II. STATES HAVE THE CONSTITUTIONAL COMPETENCE TO PROHIBIT ASSISTANCE IN SELF-DESTRUCTION

The Second Circuit's decision in *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), is based upon a flawed Fourteenth Amendment analysis, grounded upon an assertion there is no meaningful distinction between the refusal of medical procedures which might prolong life and the taking of affirmative steps which are sure to end it.[13] Relying upon case law holding that a competent patient has a right to forego or refuse life-sustaining medical treatment, the Second Circuit found a Fourteenth Amendment "liberty interest" which prevents a state from enacting laws against physicians assisting in the affirmative destruction of their patients. The Second Circuit held that such laws were not "rationally related" to any "legitimate governmental interest," and are therefore constitutionally infirm.

A fundamental fault in the Second Circuit's reasoning is the assumption that patient autonomy and the right to refuse life-sustaining treatment constitute a recognition of some constitutionally protected "right to die." The MSNJ and its physician members were in the forefront of the debate on these issues, participating in landmark cases before the Supreme Court of New Jersey which were the first in the nation to recognize and define the rights of patients near the end of life. The right of a competent patient to refuse treatment at life's end is simply an extension of the right to informed participation in treatment decisions during life, and is by no means a right to end life, no matter what the reasons.

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13 This assertion leads inexorably to an even more difficult question: if there is no such legally cognizable difference, then how can a distinction be drawn between the right of a terminally ill patient to destroy his own life via physician assisted suicide and the right of a patient who is severely debilitated or in intense, constant pain, but whose condition is not terminal, to similar "aid" in terminating his?

Past pronouncements of this Court as well recognize this crucial distinction.

As fully set forth in the first point of this brief, the medical profession has long-standing historical and ethical prohibitions against taking the lives of its patients. The states are constitutionally competent to rely upon these prohibitions to, in part, provide a rational basis to support statutes against assisted self-destruction.

A. New Jersey Has a Rich Juridical and Legislative Tradition Regarding Patient Autonomy in Treatment Decisions, Which Explicitly Rejects the Concept of Physician Assisted Self-Destruction

In *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), the Supreme Court of New Jersey recognized that the state has an interest in "the preservation and sanctity of human life," 70 N.J. at 40, but that this interest had to be balanced against a patient's Fourteenth Amendment privacy right to refuse invasive medical procedures:

> We think that the State's interest [in preserving life] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor,—she will never resume cognitive life. And the bodily invasion is very great,—she requires 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and a feeding tube.

Quinlan, 70 N.J. at 41.

With regard to physician assisted self-destruction, there is simply no right which may be balanced against the state's interest in "the preservation and sanctity of human life." A privacy interest in refusing medical intervention is in no way congruent with the liberty interest in suicide articulated by the Second Circuit. This was explicitly recognized by the *Quinlan* court:

> We would see, however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death.

Quinlan, 70 N.J. at 43. Under this rationale, a state certainly has a "rational basis" to draw a distinction between refusal of medical treatment and active self-destruction.[14]

The New Jersey Supreme Court again had occasion to consider the right to refuse medical intervention in *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). The court did not articulate anything which could be construed as a "right to die." The case involved "the circumstances under which life-sustaining treatment may be withheld or withdrawn from incompetent, institutionalized, elderly patients with severe and permanent mental and physical impairments and a limited life expectancy." *Conroy*, 98 N.J. at 335.

Stating "[t]he starting point in analyzing whether life-sustaining treatment may be withheld or withdrawn from an incompetent patient is to determine what rights a competent patient has to accept or reject medical care," *Conroy*, 98 N.J. at 346, the court again balanced the state's interest in preserving life against the patient's right to make treatment decisions under the doctrine of informed consent. *See Conroy*, 98 N.J at 346-355.

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[14] In fact, after she was withdrawn from the respirator, Karen Ann Quinlan lived for a further nine years.

The court drew a clear distinction between refusing treatment and taking life:

> In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. [citations omitted] In addition, people who refuse life-sustaining medical treatment may not harbor a specific intent to die, [citation omitted]; rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering, [citation omitted].
>
> Recognizing the right of a terminally ill person to reject medical treatment respects that person's intent, not to die, but to suspend medical intervention at a point consonant with the "individual's view respecting a personally preferred manner of concluding life." [citation omitted] The difference is between self-infliction or self-destruction and self-determination.

Conroy, 98 N.J at 350-1.

In 1987, the New Jersey Supreme Court revisited these issues in a trilogy of cases: *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *Matter of Peter by Johanning*, 108 N.J. 365, 529 A.2d 319 (1987); and *Matter of Jobes*, 108 N.J. 394, 529 A.2d 434 (1987). These cases involved the circumstances under which life-sustaining medical treatment could be withheld or withdrawn. The court balanced the interests of the state in, *inter alia*, preserving life, against the patients' rights of self-determination and informed consent. Again, the court rejected any notion that the right to refuse treatment encompassed a right to commit suicide:

> Courts in other jurisdictions have consistently agreed that refusal of life-supporting treatment does not amount to an attempt to commit suicide. *See, e.g., Bartling v. Superior Court, supra*, 163 Cal. App.3d at 195-97, 209 Cal. Rptr. at 225-6; *Foody v. Manchester Memorial Hosp.*, 20 Conn. Supp. 127, ___, 482 A.2d 713, 720 (Super. Ct. 1984); *Satz v. Perlmutter, supra*, 362 So.2d at 162-63; *Brophy v. New England Sinai Hosp., supra*, 398 Mass. at 438, 497 N.E.2d at 638; *In re Eichner, supra*, 52 N.Y.2d at 377-78 n.6, 420 N.E.2d at 71 n. 6, 438 N.Y.S.2d at 273 n. 6; *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 10, 426 N.E.2d 809, 815 (Ohio Com. Pl. 1980); *Colyer, supra*, 99 Wash.2d at 121, 660 P.2d at 743.

Farrell, 108 N.J. at 350.

The principles enunciated in these landmark cases are also reflected in New Jersey's statutes. Under New Jersey's Code of Criminal Justice:

> A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree.

N.J.S. 2C:11-6, App. G.

The *New Jersey Advance Directives for Health Care Act*, N.J.S. 26:2H-53, *et seq.*, essentially codifies the holdings in the above-discussed cases, and provides for a legally enforceable procedure for embodying an individual's advance treatment decisions in writing. The statute contains the following legislative finding:

> The right of individuals to forego life-sustaining measures is not absolute and is subject to certain interests of society. The most significant of these societal interests is the preservation of life, understood to embrace both an interest in preserving the life of the particular patient and

> a related but distinct interest in preserving the sanctity of all human life as an enduring social value. A second, closely related societal interest is the protection of individuals from direct and purposeful self-destruction, motivated by a specific intent to die.

N.J.S. 26:2H-54(d), App. F.

These cases and statutes constitute a well-established and cohesive body of law, which has evolved in harmony with the ethical tenets of the medical profession. The Second Circuit's decision both ignores and contradicts this tradition.

B. Past Pronouncements of This Court Inform and Authenticate Prohibitions Against Assistance in Self-Destruction

This Court has had occasion to consider the issues raised by the above-cited New Jersey Supreme Court cases. In *Cruzan v. Director, Missouri Health Dept.*, 497 U.S. 261 (1990), this Court upheld a Missouri statute requiring proof by clear and convincing evidence of an incompetent patient's wishes to withdraw life-sustaining medical treatment against a due process challenge. As did the New Jersey Supreme Court, this Court recognized a clear distinction between the withholding or withdrawal of medical treatment on the one hand, and the purposeful destruction of life on the other.

This Tribunal balanced Missouri's interest in the preservation of life against the patient's Fourteenth Amendment liberty interest in refusing unwanted medical treatment. It held that the state's interest in requiring proof of intention to forego life-sustaining medical treatment by a heightened evidentiary standard outweighed a patient's right to forego treatment. In so holding, the Court stated:

> Finally, we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified

> interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

Cruzan, 497 U.S. at 282.

Under the *Cruzan* decision, states have a clear and compelling interest in the preservation of life, to the extent they may require procedural safeguards which could conceivably infringe upon a patient's Fourteenth Amendment liberty interest in refusing unwanted medical treatment. It follows, without question, that the states have an even more compelling interest in enacting statutes against assistance in self-destruction; no pronouncement of this Court even hints that an individual has any constitutional right to commit suicide which might be balanced against this compelling state interest.

This "right to suicide" found by the Second Circuit has no foundation in statute or the common law. It may not be created by analogy to the right to refuse medical treatment. There is therefore nothing to "balance" in the context of a Fourteenth Amendment analysis. Indeed, in addition to New Jersey, thirty-nine other states, Puerto Rico and the U.S. Virgin Islands have statutes or common-law prohibitions against assisting suicide, or have statutes criminalizing negligent homicide which are broad enough to encompass assisted suicide.[15] The MSNJ submits that these court decisions and legislative pronouncements evince a strong interest on the part

[15] *See* Ala. Code, § 13A-6-1; Alaska Stat., § 11.41.120(a)(2); Ariz. Rev. Stat. Ann., § 13-1103(A)(3); Ark. Stat. Ann., § 5-10-104(a)(2); Cal. Pen. Code, § 401; Colo. Rev. Stat., § 18-3-104(1)(b); Conn. Gen. Stat., § 53a-56(a)(2); Del. Code Ann., tit. 11, § 645; Fla. Stat. Ann., § 782.08; Ga. Code Ann., § 16-5-5(b); Ill. Comp. Stat. ch. 720, 5/12-31; Ind. Stat. Ann., § 35-42-1-2.5(b); Ia. Code, §§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session; Kan. Stat. Ann. § 21-3406; Ky. Rev. Stat., § 216:302; La. Rev. Stat., § 14:32.12; Me. Rev. Stat. Ann., tit. 17-A, § 204; *Commonwealth v. Mink*, 123 Mass. 422, 428-29 (Mass. 1877); *People v. Kevorkian*, 447 Mich. 436, 527 N.W.2d 714 (Mich. 1994); Minn. Stat. Ann., § 609.215; Miss. Code Ann., § 97-3-49; Mo. Ann. Stat., § 565.023(1)(2); Mont. Code Ann., § 45-5-105; Neb. Rev. Stat., § 28-307; N.H. Rev. Stat. Ann., § 630:4; N.M. Stat. Ann., § 30-2-4; N.Y. Penal Law, §§ 120.30, 125.15(3); *State v. Willis*, 121 S.E.2d 854 (N.C. 1961); N.D. Cent. Code., § 12.1-16-04; *Blackburn v. State*, 23 Ohio St. 146, 163 (Ohio 1972); Okla. Stat. Ann., tit. 21, §§ 813-818; 18 Pa. Cons. Stat. Ann., § 2502; P.R. Laws Ann., tit. 33, § 4009; *State v. Jones*, 86 S.C. 17, 67 S.E. 160, 165 (S.C. 1910); S.D. Codified Laws Ann., § 22-16-37; Tenn. Code Ann., § 39-13-216; Tex. Penal Code Ann., § 22.08; V.I. Code Ann., tit. 14, § 2141; Wash. Rev. Code Ann., § 9A.36.060; Wis. Stat. Ann., § 940.12; and Wyo. Stat., § 6-2-107.

of New Jersey, other states, commonwealths and territories, in the preservation of life. This interest is bolstered by long-standing ethical precepts of the medical profession prohibiting the wilful destruction of the life of a patient. Laws prohibiting assisted suicide are rationally related to this state interest.

CONCLUSION

Accordingly, the Medical Society of New Jersey, as Friend of the Court, respectfully urges this Court, for all the foregoing reasons, and for those stated in the briefs for the petitioners and other supporting *amici*, to reverse the decision below.

Respectfully submitted,

VINCENT A. MARESSA
NEIL E. WEISFELD
THE MEDICAL SOCIETY
OF NEW JERSEY
Two Princess Road
Lawrenceville, NJ 08648-2302
(609) 896-1766

PAUL W. ARMSTRONG*
R. BRUCE CRELIN
TIMINS, LARSEN, BEACHAM
& HUGHES
85 Livingston Avenue
Roseland, NJ 07068
(201) 740-1771

Attorneys for Amicus Curiae

12 November 1996

* Counsel of Record

APPENDIX

APPENDIX A

MEDICAL SOCIETY OF NEW JERSEY STATEMENT ON PHYSICIAN ASSISTED SUICIDE

Physicians cannot serve the patient's good by deliberately eliminating the patient. There has been, is and always will be a clear distinction between causing a death as contrasted with permitting death to occur.

"Aid-in-dying," the right to die, physician-assisted suicide or euthanasia imply an obligation on the part of others to kill or help kill. There is no such right. It is difficult to imagine and configure a limited statute permitting homicide by a privileged few and exercised in the name of humanity.

Further, there is no way to confine the practice to those knowingly and really requesting death. The vast majority of persons who are candidates for assisted death are, and increasingly will be, incapable of choosing and effecting such a course of action for themselves. No one with an expensive or troublesome infirmity will be safe from the pressure to have his right to die exercised. Some reasons in favor of death might even be construed as a duty to die.

Moreover, under physician-assisted suicide, the medical profession's devotion to healing and refusal to kill, its ethical center, would be destroyed along with patient trust and physician self-constraint. Physicians do not require the tool of death.

Sentiments in support of physician-assisted suicide are understandable in a culture which at times is tempted to embrace seemingly easy solutions to complex social and moral issues. Support for physician-assisted suicide may also be fueled by a limitless sense of individual rights and personal autonomy. Popular support for physician-assisted suicide may also be the consequence of the legitimate concerns of individuals who fear that confronting death at the end of a terminal illness may result in a loss of their dignity, unrelieved pain and even abandonment by their physicians.

In the face of recent and pending court decisions, and despite popular sentiments in American culture, the Medical Society of New Jersey affirms without equivocation its opposition to euthanasia and physician-assisted suicide in any form or manner. Furthermore, the Medical Society of New Jersey endorses the official policy of the American Medical Association (Policy 140.952) which declares that "physician assisted suicide is fundamentally inconsistent with the physician's professional role." The Medical Society also endorses the Opinion of the Council on Ethical and Judicial Affairs (Opinion 2.211) which states that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."

Although the Medical Society of New Jersey stands in opposition to physician-assisted suicide, this position should not be interpreted in any way so as to compromise the ethically and legally protected right of terminally ill patients to participate fully in treatment decisions at the end of life, including the right to execute and implement advance directives and to refuse or request the withdrawal of aggressive forms of medical treatment which in the informed opinion of the patient impose burdens which outweigh the benefits.

Nor should the Medical Society's opposition to all forms of physician-assisted suicide be interpreted to compromise the right of patients to receive appropriate pain treatment to relieve suffering in the final stages of a terminal illness. The provision of appropriate pain treatment, even if in some instances this may hasten the death of the patient, does not constitute a form of physician-assisted suicide. The Medical Society of New Jersey, echoing the ethical principles espoused by the American Medical Association, recognizes a fundamental ethical distinction between actions which are directly intended to end the life of a patient and actions which have, as a secondary consequence, this effect.

Finally, we are eager that physicians throughout the state vigorously discuss responsibilities to dying patients with each

other, with other professionals, and with patients. This conversation will serve to enhance our ethics and our care.

1 November 1996

APPENDIX B

MEDICAL SOCIETY OF NEW JERSEY POLICY STATEMENT ON PHYSICIAN ADMINISTERED INJECTIONS AS A MEANS OF EXECUTION

American physicians, from the beginnings of this republic, have participated freely and enthusiastically in the wars this nation has endured, exercising, as required, their healing skills on both friend and foe. They have never been asked to take life during these conflicts, nor has it been deemed proper to ask this of them, recognizing that one of the enduring and basic ethical principles of the physician has been to conserve and preserve life in a cognitive, sapient, and vital human being.

The recent enactment of a death penalty statute in New Jersey and the suggestion that execution be by injection have, of necessity, caused the Medical Society of New Jersey to re-examine these principles. Agreement or disagreement with imposition of a death penalty and agreement or disagreement with the method of execution and its "humane" qualities are not germane to the central issue, i.e., whether a physician may ethically take human life by active participation in a legally ordered execution.

We think not, feeling that acceptance of such participation would undermine the moral and ethical foundations of medicine.

Accordingly, the Board of Trustees of the Medical Society of New Jersey reaffirms the ethical necessity for the physician to practice only the positive aspects of the healing arts and to respect the sanctity of human life, and further reaffirms the policy statement of the American Medical Association, which states that a "physician, as a member of a profession dedicated to preserving life when these is hope of doing so, should not be a participant in a legally authorized execution."

The role of a physician in pronouncing or determining the cause of death after an execution would not be affected and would continue to be acceptable.

Adopted by the Board of Trustees September 12, 1982.

APPENDIX C

AMERICAN MEDICAL ASSOCIATION OPINION 2.20: WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING MEDICAL TREATMENT

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decisionmaking capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decisionmaker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates. Physicians should provide all relevant medical information and explain to surrogate decisionmakers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences

and values. In making a substituted judgment, decisionmakers may consider the patient's advance directive (if any); the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should almost always be accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the decisionmaking process: (1) there is no available family member willing to be the patient's surrogate decisionmaker, (2) there is a dispute among family members and there is no decisionmaker designated in an advance directive, (3) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent, and (4) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decisionmaking is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.

Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of

life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis. (I,III,IV,V)

Issued March 1981 (Opinion 2.11: Terminal Illness) and December 1984 (Opinion 2.19: Withholding or Withdrawing Life-Prolonging Medical Treatment: Patient's Preferences, renumbered as Opinion 2.21 in August 1989).

APPENDIX D

AMERICAN MEDICAL ASSOCIATION OPINION 2.21: EUTHANASIA

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Issued June 1994 based on the report "Decisions Near the End of Life," issued June 1991. (JAMA, 1992;267:2229-2233)

APPENDIX E

AMERICAN MEDICAL ASSOCIATION OPINION 2.211: PHYSICIAN ASSISTED SUICIDE

Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993. (JAMA. 1992; 267: 2229-2233)

APPENDIX F

NEW JERSEY COMMISSION ON LEGAL ETHICAL PROBLEMS IN THE DELIVERY OF HEALTH CARE, *THE NEW JERSEY ADVANCE DIRECTIVES FOR HEALTH CARE AND DECLARATION OF DEATH ACTS: STATUTES, COMMENTARIES AND ANALYSES* (1991)

AN ACT concerning health care decisionmaking and supplementing Title 26 and Title 52 of the Revised Statutes.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

Section 1: Short Title

This act shall be known and may be cited as the "New Jersey Advance Directives for Health Care Act."

Section 2: Legislative Findings

The Legislature finds and declares that:

a. Competent adults have the fundamental right, in collaboration with their health care providers, to control decisions about their own health care. This State recognizes, in its law and public policy, the personal right of the individual patient to make voluntary, informed choices to accept, to reject, or to choose among alternative courses of medical and surgical treatment.

b. Modern advances in science and medicine have made possible the prolongation of the lives of many seriously ill individuals, without always offering realistic prospects for improvement or cure. For some individuals the possibility of extended life is experienced as meaningful and of benefit. For others, artificial prolongation of life may seem to provide nothing medically necessary or beneficial, serving only to extend suffering and prolong the dying process. This State recognizes the inherent dignity and value of human life and

within this context recognizes the fundamental right of individuals to make health care decisions to have life-prolonging medical or surgical means or procedures provided, withheld, or withdrawn.

c. In order that the right to control decisions about one's own health care should not be lost in the event a patient loses decisionmaking capacity and is no longer able to participate actively in making his own health care decisions, this State recognizes the right of competent adults to plan ahead for health care decisions through the execution of advance directives, such as living wills and durable powers of attorney, and to have the wishes expressed therein respected, subject to certain limitations.

d. The right of individuals to forego life-sustaining measures is not absolute and is subject to certain interests of society. The most significant of these societal interests is the preservation of life, understood to embrace both an interest in preserving the life of the particular patient and a related but distinct interest in preserving the sanctity of all human life as an enduring social value. A second, closely related societal interest is the protection of individuals from direct and purposeful self-destruction, motivated by a specific intent to die. A third interest is the protecting of innocent third parties who may be harmed by the patient's decision to forego therapy; this interest may be asserted to prevent the emotional and financial abandonment of the patient's minor children or to protect the paramount concerns of public health or safety. A fourth interest encompasses safeguarding the ethical integrity of the health care professions, individual professionals, and health care institutions, and maintaining public confidence and trust in the integrity and caring role of health care professionals and institutions. Finally, society has an interest in ensuring the soundness of health care decisionmaking, including both protecting vulnerable patients from potential abuse or neglect and facilitating the exercise of informed and voluntary patient choice.

e. In accordance with these State interests, this State expressly rejects on both legal and moral grounds the practice of active euthanasia. No individual shall have the right to, nor shall any physician or other health care professional be authorized to engage in, the practice of active euthanasia.

f. In order to assure respect for patients' previously expressed wishes when the capacity to participate actively in decisionmaking has been lost or impaired; to facilitate and encourage a sound decisionmaking process in which patients, health care representatives, families, physicians, and other health care professionals are active participants; to properly consider patients' interests both in self-determination and in well-being; and to provide necessary and appropriate safeguards concerning the termination of life-sustaining treatment for incompetent patients as the law and public policy of this State, the Legislature hereby enacts the New Jersey Advance Directives for Health Care Act.

APPENDIX G

NEW JERSEY CODE OF CRIMINAL JUSTICE—HOMICIDE

Aiding suicide

A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree. L.1978, c.95 § 2C:11-6, eff. Sept. 1, 1979.